

CHAPTER 523 TARGETED CASE MANAGEMENT

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BACKGROUND

Targeted Case Management (TCM) is the coordination of services to ensure that eligible Medicaid members have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying a member's problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist members and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid member are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs.

Targeted Case Management is not a direct service. TCM is composed of a number of federally designated components: Needs assessment and Reassessment; Development and Revision of TCM Service Plan; Referral and Related Activities; and Monitoring and Follow-up.

This chapter sets forth the West Virginia Bureau for Medical Services (BMS) requirements for payment of TCM services for members with mental illness, developmental disabilities, substance-related disorders, and/or victims of domestic violence when rendered by qualified providers to eligible West Virginia Medicaid members.

TCM services are subject to review by the BMS Office of Program Integrity (OPI). If deficiencies are found, the entity/individual who received payment for services identified would be subject to recovery of payment for services provided. Please refer to [Chapter 800, Program Integrity](#).

The relationship of the targeted case manager with a Medicaid member and his or her family should be one of a partnership. As such, members, parents, and families are not merely spectators of targeted case management recommendations, but active participants in care planning throughout the targeted case management process. This is a necessary perspective in order for the member's needs and/or preferences to be considered and addressed individually.

Accordingly, organized strategies that empower members, parents, and families to assume and carry out their responsibilities must be included in this mutual planning process. It is very important that a targeted case manager is aware of and sensitive to the values, attitudes, and beliefs that are unique to each family. Values concerning approaches and styles of parenting and/or family life vary according to culture. The effectiveness of TCM is positively impacted by a demonstrated respect for cultural variations among families. Thus, it is critical that targeted case managers be able to identify and understand cultural beliefs, values, attitudes, and morals by which members and their families operate.

TCM effectiveness is further enhanced when integrated with other services and resources identified through a systems perspective, considering all active participants in the member's life (including the member's parents, family, and significant others and any involved service providers). Interagency collaboration is crucial to ensuring that a member's needs are adequately met without duplication of services. Thus, it is important for a system to exist within each agency to ensure that targeted case managers are communicating with other professionals and involved parties, coordinating care and services and meeting the specific needs of each member and, as appropriate, the needs of families.

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PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

523.1 PROVIDER ENROLLMENT REQUIREMENTS

In order to participate in the West Virginia Medicaid program and receive payment from the BMS, each provider of TCM Services must meet all enrollment criteria as described in [Chapter 300, Provider Participation Requirements](#) and:

- Meet and maintain all BMS enrollment, certification, and service provision requirements as described in this manual.
- Be licensed under the laws of the State of West Virginia as a Behavioral Health Agency; unless the provider is a domestic violence center. Based on the 1989 Domestic Violence Act, an agency (domestic violence center) must be licensed as a domestic violence center under [Chapter 48 of the West Virginia Code](#).

523.2 TARGETED CASE MANAGEMENT AGENCY ADMINISTRATION REQUIREMENTS

TCM agencies must promote effective operation of the various programs and agencies in a manner consistent with applicable State laws, regulations, and procedures. There must be clear policy guidelines for decision making, program operations, and provision for monitoring the same.

TCM providers must have:

- Provisions for orientation, continuing education, and on-going communication with all applicable governing boards.
- Policies and procedures to protect the rights of members.
- A comprehensive set of personnel policies and procedures.
- Job descriptions and qualifications, including licensure, for all staff employed either directly or by contract with the provider or with an agency contracting with the provider or program.
- Provisions for ensuring staff or contractors possess the skills, attitudes, and knowledge needed to perform job functions, and provisions for performing regular staff evaluations.
- Written definitions and procedures for use of all volunteers must be maintained.

TCM providers must exhibit effective inter-agency coordination that demonstrates a working knowledge of other community agencies. This means the provider and its contracting agencies must be aware of the specific program goals of other human service agencies, and maintain current information regarding the types of services offered and limitations on these services. Similarly, providers must ensure that other human service agencies are provided with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services.

523.2.1 Fingerprint-Based Background Checks

All providers of any TCM services and their staff that have direct contact with Medicaid members must, at a minimum, have results from a state level fingerprint-based background check. This check must be conducted initially and again every three years. If the current or prospective employee, within the past five

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years, has lived or worked out of state or currently lives or works out of state, the agency must conduct an additional federal background check must be conducted by the Agency through the West Virginia State Police also upon hire and every three years of employment thereafter. Providers may do an on-line preliminary check and use these results for a period of three months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last five years. An individual who is providing services or is employed by a provider cannot be considered to provide services, nor can be employed or continue to be employed if ever convicted of the following:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

Fingerprint-based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse, must be considered by the provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in conviction status of an agency staff member providing TCM services, the TCM provider must take appropriate action, including notification to the BMS program manager for TCM Services.

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) must be checked by the TCM provider for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services.

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It is the responsibility of the employer to check the list of excluded individuals/entities monthly at:

- (LEIE) at: <http://exclusions.oig.hhs.gov/>
- (Formerly EPLS) <https://www.sam.gov/>

A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry, upon hiring for employment. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at <http://www.wvsp.gov>
- National sex offender registry is at <http://www.nsopw.gov/>

All payments for services provided by excluded providers or employees will be recovered by BMS

523.3 TELEHEALTH SERVICES

The West Virginia Bureau for Medical Services encourages providers that have the capability to render services via telehealth to allow easier access to services for West Virginia Medicaid members. To utilize Telehealth providers will need to document that the service was rendered under that modality. When filing a claim the Provider will bill the service code with a GT Modifier. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate.

- Minimum equipment standards are transmission speeds of 256kbps or higher over Integrated Services Digital Network (ISDN) or proprietary network connections including Virtual Private Networks (VPNs), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used as long as the software is Health Insurance Portability Act (HIPAA) compliant and abides by a federal code pertaining to telehealth.
- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.
- The provider at the distant site is responsible to maintain standards of care within the identified scope of practice.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.

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- The provider must have an appropriately trained employee of the facility available in the building at all telehealth contacts with a member. Appropriately trained is defined as trained in systematic de-escalation that involves patient management.
- The healthcare agency or entity that has the ultimate responsibility for the care of the patient must be licensed in the State of West Virginia and enrolled as a West Virginia Medicaid provider. The practitioner performing services via telemedicine, whether from West Virginia or out of state, must meet the credentialing requirements contained within this manual.
- Telehealth providers must have in place a systematic quality assurance and improvement program relative to Telehealth services that is documented and monitored.
- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- The operator of the telehealth equipment must be an enrolled provider, a contracted employee, or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary. Member's consent to receive treatment via Telehealth shall be obtained, and may be included in the member's initial general consent for treatment.
- If the member (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.
- The healthcare practitioner who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including as listed below:
 - The right to withdraw at any time.
 - A description of the risks, benefits and consequences of telemedicine
 - Application of all existing confidentiality protections
 - Right of the patient to documentation regarding all transmitted medical information
 - Prohibition of dissemination of any patient images or information to other entities without further written consent.

523.4 STAFF QUALIFICATIONS

TCM providers must assure that all staff that provides TCM services to members possesses one of the following qualifications:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse
- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:
 - Psychology;
 - Criminal Justice;
 - Board of Regents with health specialization;
 - Recreational Therapy;

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- Political Science;
- Nursing;
- Sociology;
- Social Work;
- Counseling;
- Teacher Education;
- Behavioral Health;
- Liberal Arts or;
- Other Degrees approved by the West Virginia Board of Social Work.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to: transcripts, licenses, and certificates.

TCM providers must have a review process to ensure that employees providing TCM services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.

TCM providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.

TCM providers must credential their staff by an internal curriculum specific to TCM prior to the staff assuming their TCM duties.

Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency. Documentation of staff continuing education, staff development, and TCM training must be maintained in staff personnel files. This documentation at a minimum must contain a description of the continuing education activities, and must be signed and dated by the TCM trainer and the targeted case manager.

523.5 OTHER ADMINISTRATIVE REQUIREMENTS

The TCM provider must assure implementation of the BMS policies and procedures pertaining to service planning and documentation and case record review. Case records must be arranged so the information can be found quickly and easily. Uniform guidelines for case record organization must be used by staff, so that information will be found in the same place from case record to case record. Copies of completed release of information forms and consent forms must be filed in the case record.

Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Termination reports must be filed upon case closure. There must be on-going case record reviews to ensure that records contain current, accurate, and complete information.

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523.6 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

TCM providers must comply with the documentation and maintenance of records requirements described in [Chapter 100, General Information](#) and [Chapter 300, Provider Participation Requirements](#) of the BMS Provider Manual. In addition to the documentation requirements described in this chapter, the following requirements must also be met in order to receive payment for TCM Services:

A Medicaid-enrolled provider of TCM Services must maintain the following information/documentation:

- An individual permanent clinical record for each member receiving TCM Services.
- Evidence in each clinical record that the member is shown to be in a targeted population as defined under the [Member Eligibility and Enrollment](#) section of this policy.
- An individualized service plan detailing the need for TCM services which is updated at 90-day intervals or more frequently if indicated by member need.
- A clinical record that must include documentation specific to services/activities reimbursed as Medicaid TCM. This includes a specific note for each individual case management service/activity provided and billed.

Each case note must:

- Be dated and signed by the case manager along with a listing of the case manager's credentials, e.g. ;licensed social worker (LSW), MA;
- Have relevance to a goal or objective in the member's plan of service;
- Include the purpose and content of the activity as well as the outcome achieved;
- Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts);
- Detail the TCM component of the valid activity provided; (i.e., Needs Assessment and Reassessment; Development and Revision of the TCM Service Plan; referral and related activities; and monitoring and follow-up);
- List the location the activity occurred; and
- List the actual time spent providing each activity by itemizing the start and stop time.

A TCM unit of service consists of a 15-minute period of time. Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement, the amount of time documented in minutes must be totaled and divided by 15. Partial units must be rounded down to arrive at the number of units billed. After arriving at the number of billable units, the last date services were rendered must be billed as the date of service. **The billing period cannot overlap calendar months.** The documentation must demonstrate that only one staff person's time is billed for any specific activity provided to the member.

523.7 METHOD OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Administrative requirements, as well as provision of services, are subject to review by the BMS and/or its contracted agents. The BMS contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by the BMS.

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These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in [Chapter 800, Program Integrity](#).

MEMBER ELIGIBILITY AND ENROLLMENT

523.8 CHILD ELIGIBILITY STANDARDS

A child must meet one of the two categories below to be eligible for TCM:

1. Documentation indicates that a child member is eligible for TCM because:
 - a. The child is between the ages of three through the day before their 22nd birthday; **and**
 - b. The child demonstrates a serious and persistent emotional, behavioral, developmental and/or substance use disorder as exemplified by a valid diagnosis as described in the language of the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association; and/or the current International Classification of Disease and Related Health Problems (ICD); **and**
 - c. By virtue of age and effects of the emotional and/or developmental impairments, the child is unable to perform age-appropriate activities of daily living (ADLs) without assistance and/or prompting.

OR

2. Documentation indicates that the child is eligible due to actual or pending removal from present living environment and:
 - a. The child is between the ages of three and through the day before their 22nd birthday inclusively and/or is in the custody of the West Virginia Department of Human Services (DoHS); **and**
 - b. The child is removed or is pending removal from present living environment due to allegations of abuse and neglect.

523.9 EXCLUSIONS (CHILD)

The child does not qualify for TCM if:

1. The child is currently eligible for case management services through:
 - The West Virginia Birth to Three (BTT) Program; **or**
 - Long-term care facility; **or**
 - Psychiatric residential treatment facility (PRTF); **or**
 - Receiving acute and or subacute psychiatric care, **or**
 - Enrolled through the Intellectual Developmental Disabilities Waiver (IDDW) program, **or**
 - Residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

TCM may be provided when the community-based provider develops and completes discharge planning services through TCM for eligible children 10 days prior to discharge from acute psychiatric care and 60 days prior to discharge from a long-term care program.

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OR

2. The child is receiving TCM services from another entity including a county school system.

523.10 ADULT ELIGIBILITY STANDARDS

An adult must meet one of the two categories below to be eligible for TCM:

1. Documentation indicates that an adult member is eligible for TCM because:
 - a. The adult is age 22 or older; **and**
 - b. The adult demonstrates a serious and persistent emotional, behavioral, developmental and/or substance use disorder as exemplified by a valid diagnosis as described in the language of the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association; and/or the current International Classification of Disease and Related Health Problems (ICD); **and**
 - c. By virtue of age and effects of the emotional and/or developmental impairments, the adult is unable to perform activities of daily living (ADL) without assistance and/or prompting.

OR

2. Documentation indicates that the adult is currently and temporarily residing in a licensed domestic violence shelter.

523.11 EXCLUSIONS (ADULT)

The adult is not eligible for TCM if:

1. The adult is currently receiving services through:
 - An acute psychiatric care facility; **or**
 - A state-operated psychiatric facility; **or**
 - A long-term care facility; **or**
 - Is enrolled through the IDDW program; **or**
 - Is an active and current recipient of Assertive Community Treatment (ACT); **or**
 - Residing in an ICF/IID.

TCM may be provided when the community-based provider develops and completes discharge planning services through TCM for eligible members 10 days prior to discharge from acute psychiatric care and 60 days prior to discharge from a long term care program.

OR

2. The adult is receiving TCM services from another entity.

In order to demonstrate the linkage between emotional/behavioral/developmental disability and functional impairment, the provider's documentation must reflect one or both of the following:

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1. Because of inability to process and comprehend information, the member is unable to properly act upon documents or utilize processes regarding benefit eligibility, medication management, budgeting, or otherwise performing activities required to continue to live in a community based setting;
2. Because of interpersonal problems of psychiatric symptomatology, the member is unable to cooperate with others in order to achieve goals and obtain services necessary for community living.

POLICY

523.12 COMPONENTS OF TARGETED CASE MANAGEMENT SERVICES

TCM services are federally defined as "those services which assist Medicaid eligible recipients in the target group to gain access to needed medical, behavioral health, social, educational, and other services." **Targeted Case Management is not a direct service.**

Within TCM services are four activities federally recognized as components of targeted case management. These components are:

- **Needs Assessment and Reassessment:** Reviewing of the member's current and potential strengths, resources, deficits, and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible member, his or her parent (s) and/or guardian and the case manager to determine whether services are needed and, if so, to develop a service plan. At a minimum an annual face to face reassessment shall be conducted to determine if the member's needs or preferences have changed.
- **Development and Revision of the TCM Service Plan:** Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed but the member, his or her parent (s) or legal guardian and the case manager. Development (and periodic revision) of the TCM Service Plan which will specify the goals and actions to address the medical, social, educational, and other services needed by eligible member's needs. Periodic revisions to the TCM Service Plan will be made at a minimum annually.
- **Referral and Related Activities:** Facilitating the member's access to the care; services; and resources through linkage; coordination; referral; consultation; and monitoring. This is accomplished through in-person and telephone contacts with the member, his or her parent(s), or legal guardian, and with service providers and other collaterals on behalf of the member. This will occur as necessary, but at least annually. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the member, his or her parent(s) or legal guardian and the case manager and between the member, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes advocating for the member in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific member. This may also

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include acquainting the member, his or her parent(s), or legal guardian with resources in the community and providing information for obtaining services through community programs.

- **Monitoring and Follow-up Activities:** The case manager shall conduct regular monitoring and follow-up activities with the member, the member's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the member's TCM Service Plan. Periodic review of the progress the member has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of TCM services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the member and other involved parties. The periodic reviews will be conducted as necessary but at least annually. To bill the monitoring and follow-up component one of the first three TCM Components must have been rendered for the targeted case manager to monitor or follow up on.

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Procedure Code: T1017

Service Units: 15 minutes

Prior Authorization: Yes

Telehealth: Yes, excluding the 90 day face to face contact

If, between regular service planning sessions, the member requires access to a service not previously mentioned on the case management section of his/her service plan, both the member (or their legal guardian) and their case manager must agree and attach an addendum signed and dated by the targeted case manager and the member (or their legal guardian) addressing the needed service to the plan.

For continued eligibility one valid TCM Activity must be rendered for the member at least every 30 days.

The case manager must have at least one face-to-face contact for a valid TCM activity with the member every 90 days. Any TCM service may be conducted via Telehealth (*refer to [Section 523.3 Telehealth Services](#)*) with the exception of the 90-day face-to-face encounter with the targeted case manager.

523.13 MEMBER CHOICE OF SINGLE TARGETED CASE MANAGEMENT

Each member or their legal guardian must be provided information, by the provider with whom they are seeking services, about the availability of all Medicaid-enrolled providers rendering TCM services.

The member must be given an opportunity to choose only one approved TCM provider and must indicate this choice on the BMS-approved "Medicaid Targeted Case Management Member Enrollment" form.

A signed copy of the "Medicaid Targeted Case Management Member Enrollment" form must be retained in the member's record and must serve as an enrollment, disenrollment, or re-enrollment of the member with the provider.

The BMS reimburses only for TCM services provided by the Medicaid-enrolled provider chosen by the member.

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A member may choose a new TCM provider at any time. The effective date of the change of providers will be the first day of the month following the change.

523.14 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of TCM Services will apply pursuant to the following limitations.

- The BMS requires that providers obtain prior authorization for all TCM Services from the BMS utilization management contractor (UMC).
- General information on prior authorization requirements for TCM Services and contact information for submitting a request may be obtained by contacting the UMC.
- Prior authorization requests for TCM services must be submitted within the timelines required by the UMC.
- Prior authorization requests must be submitted in a manner specified by the UMC.

523.15 SERVICE LIMITATIONS AND EXCLUSIONS

General service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to [Chapter 300, Provider Participation Requirements](#) of the Provider Manual. In addition to the requirements for payment of services described in this chapter, TCM Services will not be authorized prior to a member's discharge from an ICF/IID or an inpatient psychiatric facility except for those provided within 10 days prior to discharge from acute psychiatric care or 60 days prior to discharge from long term care.

In addition to the exclusions listed in [Chapter 100, General Information](#) of the BMS Provider Manual, members who receive case management services under the Home and Community-Based Services Waivers granted under Section 1915(c) of the Social Security Act are excluded from receiving TCM reimbursement through this service option.

Payment for TCM services must not duplicate payments made to other entities for case management/service coordination services.

Non-covered services are not eligible for a DoHS Fair Hearing or a Desk/Document review.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Credentialing Officer: An individual approved to provide targeted case management services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners.

A provider agency with few clinical staff may designate a credentialing officer.

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Designated Legal Representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

Indirect Service: A service that is designed to support the member in his or her community- based setting. An indirect service is not designed to change behavior or emotional functioning.

Internal Curriculum: The training protocol developed and approved by the agency for staff providing Targeted Case Management services.

Present Living Environment: The location of where the child or adult receiving Targeted Case Management Services physically resides.

Targeted Case Management Service Plan: A written description of the behavioral health services and/or supports that the member is to receive. A TCM Service Plan may be otherwise named a "Plan of Service," "Treatment Plan" or other appropriate title.

REFERENCES

West Virginia State Plan references Targeted Case Management services at [sections 3.1-A\(19\)](#), [3.1-B\(19\)](#), [Supplement 1 to attachment 3.1-A](#) and reimbursement at [4.19-B\(19\)](#).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Targeted Case Management	July 1, 2016